MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

01697

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County Montgomery

City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, Institution, or~~ street address where death occurred:
132 - Maple Ave.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 132 Maple Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Winfred B Atkins

3. (b) Social Security Number 717-12-5537

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	DIVORCED

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY - 5TH 1900

8. AGE: Years	Months	Days	If less than one day
45	8	28	hrs. min.

9. Birthplace Loty - Ill.
(Town, county, and state)

10. Usual occupation TREE SURGEON.

11. Industry or business

FATHER 12. Name FRANK L ATKINS

13. Birthplace VIRGINIA.

MOTHER 14. Maiden name BLANCHE R. SHENK

15. Birthplace LORAY - VA.

16. Informant MRS. GLADYS V. SINGLETON.

Address 2010 - 37TH ST SE. WASH. DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof FEB. 5. 1946 (month) (day) (year)

Cemetery ~~or crematory~~ BETHEL

Location ALEXANDRIA. ALEXANDRIA Co VA.

18. Funeral director Daniel E Pumphrey.

Address 8434 Ga Ave - Silver Spring, Md

19. 2-4-46 (Date rec'd by registrar) 19 46 Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 19 46, at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Examiner case 19 to 19

and that I last saw h alive on 19

	DURATION
Immediate cause of death Asphyxia	Few min.
Due to Smoke and Fire	
accidental	
Due to a burning building was involved. Cause	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-3-46

Where did injury occur? Kensington (City or town) Montg (County) Md (State)

Injured at home, farm, Industry, public place (where?) Home

Means of injury Injured at work?

23. SIGNATURE Frank J Brockett Med Exam M. D. or other

Address Starkenburg md Date signed 2-3-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

01698

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery Co.
City or town: Rural Wash, D.C.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred: Glen Echo Heights
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: M.D. County: Mont.
City or town: Glen Echo Hts
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6201 - Walhonding Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: EMMA LOUISE BARRINGTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMAL	WHITE	WIDOWED

6.(b) Name of husband or wife: JOHN S. BARRINGTON
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct. 8, 1862 Oct. 8, 1862

8. AGE: Years: 83 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Brooklyn, N.Y. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: —

FATHER
12. Name: William Lewis
13. Birthplace: London Eng

MOTHER
14. Maiden name: Emma Cauder
15. Birthplace: London, Eng

16. Informant: Lewis Barrington
Address: 6201 - Walhonding Rd.

17. Burial, cremation, or removal. Which?: Burial
Date thereof: Feb. 12, 1946 (month) (day) (year)
Cemetery or crematory: Oak Hill
Location: Wash. D.C.
18. Funeral director: Joseph Gawler's Sons
Address: 1756 - Pa. Ave. NW
19. (Date rec'd by registrar): 2/9/1946 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9 1946, at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8 1946, to Feb. 9 1946
and that I last saw her alive on February 8 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	5 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John L. Swartzwout, M.D., M. D. or other
Address: 4817-14th St. N.W. Date signed: 2/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

01699

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
109 Quincey Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 109 Quincey Street
(If rural, give LOCATION)
2.(a) If veteran, name war: Army service 1892-1897

3.(a) FULL NAME: James Bigham

3.(b) Social Security Number: 577-34-6809

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Alicia Bigham 6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): October 10, 1874

8. AGE:

Years	Months	Days	If less than one day
71	4	15	...hrs. ...min.

9. Birthplace: Cleveland, Tennessee (Town, county, and state)

10. Usual occupation: Retired Washington Police

11. Industry or business

FATHER
12. Name: Asbury Bigham
13. Birthplace: Tennessee

MOTHER
14. Maiden name: Sara Carver
15. Birthplace: Tennessee

16. Informant: Margaret Alicia Bigham
Address: 109 Quincey St., Chevy Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 27, 1946 (month) (day) (year)
Cemetery or crematory: Arlington Nat'l Cemetery
Location: Arlington, Virginia

18. Funeral director: W. Reuben Groves Sons
Address: 7557 Wisconsin Ave Bethesda

19. 2/25 1946 (Date rec'd by registrar) Wm E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 25, 1946, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19, 1945 to Feb 25, 1945 and that I last saw him alive on Feb. 24, 1945

Immediate cause of death	DURATION
acute myocardial insufficiency	1 wk.
Due to: Chronic Cardio-vascular disease	2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. G. Bauersfeld M.D. M. D. or other
Address: Bethesda, Md. Date signed: 2/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(over)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01700

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8009 Eastern Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: X

3.(a) FULL NAME: HORATIO O. BLAND

3.(b) Social Security Number: X

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Grace G.
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 25th. 1878

8. AGE: Years	Months	Days	If less than one day
67	6	17	..... hrs. ..... min.

9. Birthplace: Pelahatchie, Miss. (Town, county, and state)
10. Usual occupation: Goverment Employee
11. Industry or business: Federal Public Housing

FATHER
12. Name: William Bland
13. Birthplace: N. C.

MOTHER
14. Maiden name: Harriet Pettus
15. Birthplace: Alabama.

16. Informant: Mrs. Grace G. Bland
Address: 8009 Eastern Ave. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 14th. '46 (month) (day) (year)
Cemetery: Fort Lincoln
Location: Prince Georges Co. Md.
18. Funeral director: Wood & Pumphrey
Address: Silver Spring, Md.

19. 3/7 1946 (Date rec'd by registrar) Wm E Jules Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 12 1946 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8 1946, to Feb 11 1946
and that I last saw him alive on Feb 11 1946

Immediate cause of death	DURATION
Cardiac failure	1 day
Due to Hemorrhage from duodenal ulcer	1½ mo.
Due to Coronary Heart disease	6-7 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Operation for Rupture of duodenal ulcer
Date of op. Dec 31, 1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank G. Zack M.D. M. D. or other
Address: 112 Grenville Dr. Silver Spring Date signed: March 7, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Silver Spring, Md.
March 7th. 1946

This certificate replaces original CERTIFICATE OF DEATH issued at time of death and which was lost in the mail, between Silver Spring and Bethesda, Md. after a Burial permit was issued at Silver Spring, Md.

The first death certificate stated July 25th. 1880 as birth date and age as 65 years; 6 months; 17 days; That was erroneous, and is corrected hereon.

Warner E. Pumphrey.
Funeral Director.

F.L.Z.
J.M.S.

01701

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL Bethesda, Md.

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1238 Franklin St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: X

3.(a) FULL NAME: William Henry BOLDEN, COS USN Retired, Inactive

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	married

6.(b) Name of husband or wife: Pearl Bolden

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 2-28-90

8. AGE:

Years	Months	Days	If less than one day
55	11	23	..... hrs. ..... min.

9. Birthplace: Arlington, Va. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Naval Reserve

FATHER
12. Name: Joseph Bolden
13. Birthplace: Virginia

MOTHER
14. Maiden name: Louise Holland
15. Birthplace: Virginia

16. Informant: Mrs. Pearl Bolden
Address: 1238 Franklin St, NE Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-2-46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: McGuire Funeral Home W. J.

Address: 1820 9th St. N.W. Washington, D.C.

19. 23 Febuary 19 46 (Date rec'd by registrar) mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 Feb. 19 46 at 11:25A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3 Feb. 19 46 to 23 Feb. 19 46

and that I last saw him alive on 23 Feb. 19 46

	DURATION
Immediate cause of death: Thrombosis	
coronary artery	24-48hs
Due to: arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: None or obtained

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. C. Thompson C. C. THOMPSON, Lt.Comdr. (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed 2-23-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01702

CERTIFICATE OF DEATH

Reg. Diat. No. 211

1. PLACE OF DEATH:
County: Montgomery
City or town: Woodfield
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R#1 Woodyield
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Donald Bowie Jr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Laura Bowie
6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): July 22 - 1909

8. AGE:	Years	Months	Days	If less than one day
	34	6	16	...hrs. ...min.

9. Birthplace: Aspen, Montgomery Co. Md.
(Town, county, and state)
10. Usual occupation: lawyer
11. Industry or business: —

FATHER
12. Name: Donald Bowie Sr.
13. Birthplace: Olney, Md.

MOTHER
14. Maiden name: Annie Stonestreet
15. Birthplace: Hamden, Connecticut.

16. Informant: Mrs. Donald Bowie Jr.
Address: Gaithersburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 10 1946 (month) (day) (year)
Cemetery or crematory: Wesley Grove Mem
Location: Woodfield, Maryland

18. Funeral director: J. B. Beall, Inc
Address: Damascus, md.

19. Feb 9 1946 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/8/46 at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/10/45 to 2/8/46 and that I last saw him alive on 2/7/46

Immediate cause of death	DURATION
Mediastinal Sarcoma	5 mo.
Due to: Secondary to	
Sarcoma of right ulna	1 year
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Sandy Spring Md. Date signed: 2/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

01703

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Silver Run Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Frances Virginia Bowman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Geo. Edward Bowman 6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): January 23, 1869

8. AGE: Years	Months	Days	If less than one day
77	0	9	...hrs. ...min.

9. Birthplace: Silver Run, Md. (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: own home.

FATHER — 12. Name: Tobias Dallas Coon

13. Birthplace: Silver Run, Md

MOTHER — 14. Maiden name: Eliza Frank Coon

15. Birthplace: Silver Run, Md

16. Informant: Jennie Mabel Brown

Address: Virginia

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 4 / 46 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Silver Run, Md

18. Funeral director: G. B. Little & Son

Address: Littlestown, Pa.

19. Feb 2 1946 (Date rec'd by registrar) Alverda G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2 1946, at 2:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 1945, to Feb 2 1946

and that I last saw h... alive on Feb 2 1946

Immediate cause of death	DURATION
Hemiplegia, left side.	
Due to: Hemorrhage of Brain	
Due to:	
Other conditions: Chronic Nephritis.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Mary Shurley M.D. (M. D. or other)

Address: Gaithersburg, Md. Date signed: Feb 2, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01704

CERTIFICATE OF DEATH

★ Reg. Diat. No. 213

1. PLACE OF DEATH:
County Moulgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? + Months
Hospital, institution, or street address where death occurred: 205 - West Monty Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Moulgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 205 - West Monty Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Jane Biays Bradley

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Henry Bradley
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): March 12 1864.
8. AGE: Years: About 81 | Months | Days | If less than one day: hrs. min.
9. Birthplace: Moulgomery Co - Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: William A. Veirs
13. Birthplace: Maryland
MOTHER 14. Maiden name: Rebecca Thomas
15. Birthplace: Maryland
18. Informant: Mr. Stribler C. Trammell (son)
Address 205 - W. Monty Ave Rockville Md
17. Burial (Burial, cremation, or removal) Which? Date thereof Feb 12 46 (month) (day) (year)
Cemetery or crematory Rockville Union Cem.
Location Mr - Rockville - Monty Co - Md
18. Funeral director Wm. Reuben Pumphrey
Address Rockville - Maryland
19. 2/11/46 (Date rec'd by registrar) Josephine D. Mellon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Feb 1946 at 2A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 1945 to 9 Feb 1946
and that I last saw h... alive on 8 Feb 1946

Immediate cause of death	DURATION
Cerebral Thrombus	10 days
Due to Arteriosclerosis	15 yrs
Due to	
Other conditions Acute Congestive Heart Failure	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W S Murphy M.D.
M. D. or other
Address Rockville Md Date signed 11 Feb 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-B)

CERTIFICATE OF DEATH

★ 01705

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Place of residence 1 yr.
Hospital, institution, or street address where death occurred:
8716 Colesville Rd
How long in hospital or institution? Residence

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8716 Colesville Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas Duncan Brown

3.(b) Social Security Number: 438-07-9056

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Caucasian	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: 34 years
7. Birth date of deceased (mo., day, yr.): April 19 1911

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
34	9	13		

9. Birthplace: Boston, Mass. (Town, county, and state)
10. Usual occupation: Chemist
11. Industry or business: American Cleaners & Dyers Inc.
FATHER 12. Name: James Howard Brown
FATHER 13. Birthplace: Jacksonville Ill.
MOTHER 14. Maiden name: Dessaw Duncan
MOTHER 15. Birthplace: Franklin Ill.
16. Informant: Dr. James Howard Brown (father)
Address: 27 Merrymount Rd. Baltimore, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/2/46 (month) (day) (year)
Cemetery or crematory:
Location: Balto. Md.
18. Funeral director: A. H. Hines Co.
Address: 2901-14th St. N.W.
19. Feb 2 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 1 19 46 at 7:40 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1945 to 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Cyanide Poisoning	Few min.
Due to: Suicide	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of 2-1-46
Where did injury occur? Silver Spring (City or town) Md. (County) (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bouchard M. D.
M. D. or other
Address: Frederick Md. Date signed: 2-1-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46) X

01706

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mon., - 4days

Hospital, Institution, or street address where death occurred:
Suburban Hosp., - Bethesda Maryland

How long in hospital or institution? 2 mon., - 4days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Calvert

City or town Huntington
(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Thomas Browne

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of ~~husband or~~ wife ? — Deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1873

8. AGE: Years	Months	Days	If less than one day
72	3	25	..... hrs. ..... min.

9. Birthplace ? Ireland
(Town, county, and state)

10. Usual occupation minister — Retired

11. Industry or business

FATHER 12. Name ? Browne

FATHER 13. Birthplace ? Ireland

MOTHER 14. Maiden name ?

MOTHER 15. Birthplace Ireland

18. Informant Asst. Recorder

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/16/46 (month) (day) (year)

Cemetery or crematory Wash. Natl. Mems. Cemetery

Location Falls Church Va.

18. Funeral director W. W. Chambers Co

Address 1400 Chapin St. N.W. Wash. D.C.

19. 2/13 1946 (Date rec'd by registrar) Mrs E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13-46 19..... at 11 55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 1945 to 2/13 1946 and that I last saw h... alive on 2/13 1946

Immediate cause of death	DURATION
starvation	
Due to carcinoma of stomach	
Due to	
Other conditions metastases to liver,	

(Include pregnancy within 3 months of death)

Major findings of operations carcinoma of stomach c metastases Date of op.

Autopsy results Carcinoma of stomach ? Necrosis of myocard

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Sophie Nowadowsky MD (M. D. or other)

Address Suburban Hospital Date signed 2/13/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01707

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital Bethesda, Md.

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3616 Ordway St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME: COOK, Merlyn Grail, Captain USN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	Married

6.(b) Name of husband or wife: Mrs. Helen B. Cook

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 20, 1882

8. AGE: Years	Months	Days	If less than one day
63	10	2	..... hrs. ..... min.

9. Birthplace: Ind.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER — 12. Name: Seth A. Cook
13. Birthplace: Ind.

MOTHER — 14. Maiden name: Mary McKinsey
15. Birthplace: Ind.

16. Informant: wife: Mrs. Helen B. Cook
Address: 3616 Ordway St., N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2-26-46 (month) (day) (year)

Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: George W. Wise Co. J.C.F.
Address: 2900 M St. NW Washington, D.C.

19. 2-22-46 (Date rec'd by registrar) 19..... Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 Feb. 1946 at 9:31P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Feb. 1946 to 22 Feb. 1946 and that I last saw h... im alive on 22 Feb. 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 days
Due to: Hypertension	
Due to: Cerebral Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. L. Jones, Jr. H L Jones Jr. Comdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed 2-22-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

3/2/46

01708

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16/C

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? admitted dead
Hospital, Institution, or street address where death occurred:
(died enroute to hospital)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Lincoln Park
(If rural, give LOCATION)
2.(n) If veteran, name war

3.(a) FULL NAME: DAVIS, Ellen Michlen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(n) Single, married, widowed, or divorced
female	Colored	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 3, 1945

8. AGE: Years	Months	Days	If less than one day
	8	15	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Edward William Davis
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Ellen Louise Nickons
15. Birthplace: Md.

16. Informant: father Mr. Edward W. Davis
Address: Lincoln Park, Rockville, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2-20-46 (month) (day) (year)

Cemetery or crematory: Lincoln Park
Location: Rockville, Md.

18. Funeral director: Robert Snowden R. L. Snowden
Address: Washington St., Rockville, Md.

19. 2-18 19 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 Feb. 19 46 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Cerebral edema	12 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Cerebral edema
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Bronhart M.D. Sept. Med. Exam M. D. or other
Address: Gaithersburg, Md. Date signed 2-18-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24-P)

01769

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 Days

Hospital, Institution, or street address where death occurred:
Naval Hospital Bethesda, Md.

How long in hospital or institution? 34 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 72 Allison St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME
BERARDO, DIGIACOMO V. B. P.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W*US	married

6.(b) Name of husband or wife: Mrs. Anna Digiacomo

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 12-18-86

8. AGE: Years	Months	Days	If less than one day
59	1	24	..... hrs. ..... min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual occupation: Watchman

11. Industry or business

FATHER
12. Name: Dominick Digiacomo
13. Birthplace: Italy

MOTHER
14. Maiden name: Maryanna (unknown)
15. Birthplace: Italy

16. Informant: Wife; Mrs. Anna Digiacomo
Address: 72 Allson St. NE Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 2-15-46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers.
Address: 1400 Chapin St. NE Wash., D.C.

19. 12 Feb 1946 19..... (Date rec'd by registrar) Mary C. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 February 19 46 at 0340 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 January 19 46, to 12 February 19 46 and that I last saw him alive on 12 February 19 46

	DURATION
Immediate cause of death: congestive heart failure	2 mo
Due to: Pulmonary fibrosis	
Due to:	
Other conditions: cirrhosis of liver, ascites, splenomegaly (Include pregnancy within 3 months of death)	2 yrs

Major findings of operations: ..... Date of op. Autopsy

Autopsy results: Pulm. fibrosis, cirrhosis of liver, splenomegaly, &

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles W. Thompson M. D. or other

Address: U.S.N. Hosp. Beth. Md. Date signed: 2-16-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (3/20/46)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

01710

Reg. Dist. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Dickerson Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life Time

Hospital, Institution, or street address where death occurred: None

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Monty

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural near Dickerson
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Edward Dorsey, John Edward

3.(b) Social Security Number 214-18-8562

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
	Col	married

6.(b) Name of husband or wife Mable E. Dorsey

Dickerson Md. 6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
51	May	28	hrs. min.

9. Birthplace (Martinsburg) R.F.D. 2 Dickerson, Md.
(Town, county, and state)

10. Usual occupation Labor

11. Industry or business

FATHER 12. Name Frederick N. Dorsey

13. Birthplace Martinsburg Md.

MOTHER 14. Maiden name Charlett Ball

15. Birthplace Martinsburg Md.

16. Informant Mable E. Dorsey

Address Dickerson Md.

17. Burial Date thereof Feb 19 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Martinsburg Md.

Location near Dickerson

18. Funeral director Clarence H. Davis

Address Poolesville Md.

19. Feb. 19 1946 Charles W. Gilpin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1946 at 6:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	dead suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Bouchat M.D.
Dep. Med. Exam.
M. D. or other

Address Gaithersburg Md Date signed 2-16-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7?)

01711

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County Montgomery
City or town Seneca, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Seneca
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Geo. Samuel Driver

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife Richie Driver
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 14th 1895

8. AGE: Years 51 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Golden Driver
13. Birthplace md

MOTHER
14. Maiden name Harriet Ann Cooley
15. Birthplace md

16. Informant Richie Driver
Address Seneca, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 28th 1946 (month) (day) (year)
Cemetery or crematory Seneca
Location Seneca, Md.

18. Funeral director Robert L. Snowden
Address 246 N. Wash. St. Rockville, Md.

19. 2/28/46 (Date rec'd by registrar) Josephine D. Wootton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1946 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med Exam to case 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Cerebral edema	1 day
Due to: Chronic alcoholism	6 mo.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Bronchart M.D. M. D. or other
Address Gaithersburg md Date signed 2-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

01712

★ Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution? 36 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Laytonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Jerry Dyson.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

8.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 12, 1869

8. AGE:	Years	Months	Days	If less than one day
	76	3	22	hrs. min.

9. Birthplace Montgomery Co., Maryland (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Benjamin Dyson

13. Birthplace Maryland.

MOTHER 14. Maiden name Kathryn Pyles

15. Birthplace Maryland.

16. Informant Hospital records

Address —

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 6/1946 (month) (day) (year)

Cemetery or crematory Rockville mod

Location Montgomery County

18. Funeral director Roy W. Barber

Address Laytonsville md

19. Feb 5 1946 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1946, at 10:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 30 1945 to February 4 1946 and that I last saw him alive on February 4 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days
Due to Grand mal seizures	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md Date signed 2/4/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 01713

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery Co., Md.
City or town: Takoma Park.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? three mos.
Hospital, Institution, or street address where death occurred: Washington Sanitarium Hospital
How long in hospital or institution? three mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: ... County: ...
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 533 - 20th St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ...

3.(a) FULL NAME: Faulkner, Flora

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	W	S

6.(b) Name of husband or wife: X
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Nov 1, 190[illegible]

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
43	3	16		

9. Birthplace: Brevard, Transylvania Co., No. Carolina (Town, county, and state)
10. Usual occupation: Secretary
11. Industry or business: Government
FATHER 12. Name: William Henry Faulkner
13. Birthplace: Georgia
MOTHER 14. Maiden name: Flora Horrice Goodson
15. Birthplace: No. Carolina.
18. Informant: Hospital Records
Address: ...

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 18, 1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md.
18. Funeral director: Jas. Sanders Sons
Address: 1756 Pa. Ave. N.W.
19. Feb 16 1946 (Date rec'd by registrar) J. A. Dudley. Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 16 1946, at 11:10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 13 1945 to Feb 16 1946
and that I last saw her alive on Feb 16 1946

Immediate cause of death	DURATION
Carcinoma of K. Kidney	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: X
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Robert A. Bare M.D.
M. D. or other
Address: Takoma Park, Md. Date signed: 2/16/46

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

1714

Reg. Diat. No. 223

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Penna. County Centre
City or town State College
(If outside city or town limits, write RURAL and give nearest town)
Street No. #29 West Pa. Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Estelle Fleming

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband ~~or wife~~ Mr. George Fleming 6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1877

8. AGE: Years	Months	Days	If less than one day
69		25 da.	hrs. min.

9. Birthplace West Newton, Pa.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name C. H. Anderson
13. Birthplace Penna.

MOTHER
14. Maiden name Sue MacLenberry
15. Birthplace Penna.

16. Informant Washington San & Hosp. Records
Address Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 11, 1946 (month) (day) (year)
Cemetery ~~or crematory~~ Centre County Memorial Park
Location State College, Pa.
18. Funeral director Warner E. Pumphrey
Address Silver Spring Md.
19. February 9 1946 (Date rec'd by registrar) E. B. Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1946 at 4:34 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946 to Feb. 8 1946
and that I last saw h~~er~~ alive on Feb. 8. 1946

Immediate cause of death	DURATION
Coronary Occlusion	2 minutes
Due to Arteriosclerosis Coronary	2 yrs.
Due to Generalized Arteriosclerosis	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results Confirms Clinical
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert A. Stare M.D.
M. D. or other
Address Takoma Park Md. Date signed 2/8/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1572)

CERTIFICATE OF DEATH

01715

★ Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ days

Hospital, institution, or street address where death occurred: Washington Sanitarium and Hospital

How long in hospital or institution? 1½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 105 Westmoreland Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME George Austin Folger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	—

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): February 25, 1946

8. AGE: Years	Months	Days	If less than one day
		1	18 hrs. 17 min.

9. Birthplace: Takoma Park, Md.

(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Arthur Francis Folger

13. Birthplace: Massachusetts

MOTHER

14. Maiden name: Dorothy Elizabeth Boyer

15. Birthplace: Harrisburg, Pennsylvania

16. Informant: Washington Sanitarium Records

Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 28, 1946. (month) (day) (year)

Cemetery or crematory: Geo. Wash. Memorial Cemetery.

Location: Riggs Rd. Prince Geo. Co. Hyattsville, Md.

18. Funeral director: Arthur Sellers.

Address: 254 Carroll St. N.W. Takoma Park, D.C.

19. Feb. 28 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27 1946, at 7:15 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 25 1946 to Feb 27 1946 and that I last saw him alive on Feb 26 1946

	DURATION
Immediate cause of death: Anoxia	48 hrs.
Due to: Congenital Heart disease	48 hrs. & totally
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: Arteries to head arising from Pulmonary Artery

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Marcus A. Bowen M.D.

M. D. or other

Address: Date signed: Feb 27 1946

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89)

FILM No. I 00 FEB 13 1946

CERTIFICATE OF DEATH

01716

Reg. Dist. No. 213-

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred: 727 - West Montg Ave
How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty -
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 727 - W - Monty Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Nellie B. Franklin. **3. (b) Social Security Number:**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced	6.(c) If alive, give age
Female	White	Widowed	years

B.(b) Name of husband or wife: William Franklin

7. Birth date of deceased (mo., day, yr.): October 16 - 1874

8. AGE: Years	Months	Days	If less than one day
71 - 72 -	3	16	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:
12. FATHER — Name: Gilbert Burnett
13. FATHER — Birthplace: Unknown
14. MOTHER — Maiden name: Sarah Allen
15. MOTHER — Birthplace: Maryland
16. Informant: Mrs. Lillian Peary (sister)
Address: 727 - W - Montg Ave Rockville
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 4 - 1946 (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Washington D.C.
18. Funeral director: Wm Coulter Pumphrey
Address: Rockville - Maryland
19. 2/3/46 (Date rec'd by registrar) Josephine D. Hilton, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 Feb 1946 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to 17 Feb 1946 and that I last saw h.. alive on 17 Feb 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hrs
Due to: Arteriosclerosis	15 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. S. Murphy M.D. M. D. or other
Address: Rockville Md Date signed: 2-Feb-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

01717

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:
7216 Wisconsin Avenue, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7216 Wisconsin Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME Mr. Joseph Fricks

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Effie V. Fricks

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): August 13, 1884

8. AGE: Years	Months	Days	If less than one day
61	6	13	...hrs. ...min.

9. Birthplace: South Carolina
(Town, county, and state)

10. Usual occupation: Restaurant business

11. Industry or business: Restaurant

FATHER
12. Name: James L. O. Fricks
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Henretta Tody
15. Birthplace: South Carolina

16. Informant: Effie V. Fricks

Address: 7216 Wisconsin Ave., Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 28, 1946 (month) (day) (year)

Cemetery or crematory: Rockville Union Cemetery

Location: Rockville, Maryland

18. Funeral director: W. Reuben Humphreys

Address: Bethesda Md

19. 2/28 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 26, 1946, at 3-30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 24 1946 to Feb. 26, 1946 and that I last saw h... alive on Feb. 26, 1946.

	DURATION
Immediate cause of death: Cerebral hemorrhage	2 days
Due to: Chr. arteriosclerosis	5 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. G. Bauserfeld M. D.
M. D. or other

Address: Bethesda, Md. Date signed: 2/26/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64)

CERTIFICATE OF DEATH

01718

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution? 26 hrs 15 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frank C. Gibson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 27 Jan. 1937

8. AGE: Years	Months	Days	If less than one day
9	0	9	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER 12. Name Raymond Gibson

13. Birthplace ?

MOTHER 14. Maiden name Viola ?

15. Birthplace ?

16. Informant Raymond Gibson
Address Emory Grove, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Sept 8th 1946
(month) (day) (year)

Cemetery or crematory Emory Grove

Location Emory Grove, Md

18. Funeral director Robert L. Snowden

Address 246 N. Wash. Rockville, Md

19. 2-8-46 19
(Date rec'd by registrar)
M E Gobes
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 February 1946, at 4:10 P. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 4 Feb. 1946, to 5 Feb. 1946, and that I last saw h/im alive on 5 Feb. 1946

Immediate cause of death	DURATION
(a) Status lymphaticus	?
Due to: ?	
Due to:	
Other conditions: Secondary anemia	1 day

(Include pregnancy within 3 months of death)

Major findings of operations: 1. Chronically infected Tonsils, 2. redundant prepuce. Date of op. 5 Feb. 1946

Autopsy results: enlarged thymus, spleen, abdominal and thoracic lymph nodes. pallor. 300 cc. blood in stomach

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Stuart Drown, Jr. M.D.
M. D. or other

Address Suburban Hospital Date signed 6 Feb. 1946.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 446

CERTIFICATE OF DEATH

Reg. Dist. No. 216 017

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos 12 days

Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 2 mos 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: New Jersey County: Monmouth

City or town: Long Branch
(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 Locust Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: GOODRIDGE, Charles Victor, S2c V6 USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white-US	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 16 April 1927

8. AGE: Years	Months	Days	If less than one day
18	10	6	hrs. min.

9. Birthplace: Red Bank, New Jersey
(Town, county, and state)

10. Usual occupation: U. S. Navy

11. Industry or business:

FATHER
12. Name: Victor C. Goodridge
13. Birthplace: Wales

MOTHER
14. Maiden name: Ivy Stevenson
15. Birthplace: Canada

16. Informant: Father: Victor C. Goodridge
Address: 21 Locust Ave., Long Branch., N.J.

17. removal (Burial, cremation, or removal. Which?) Date thereof 2-23-46 (month) (day) (year)

Cemetery or crematory:

Location: Long Branch, N.J.

18. Funeral director: George W. Wise Co. J.C.F.
Address: 2900 M St. NW, Washington, D. C.

19. 2-23 (Date rec'd by registrar) 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 February 19 46, at 6:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10 19 45 to 22 Feb. 19 46 and that I last saw him alive on 22 Feb. 19 46

Immediate cause of death	DURATION
Hodgkins Sarcomatosis	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. B. Shuler J. B. Shuler, Comdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 2-23-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-C

01720

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 16 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. ~~Md.~~ County: ~~Mont.~~

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7607 Eastern Avenue, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: HARDING, Orindo Ray

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Dr. Dean H. Harding

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 2 July 1915

8. AGE: Years	Months	Days	If less than one day
30	7	16	..... hrs. ..... min.

9. Birthplace: Kansas
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: Roscoe C. Ray

FATHER — 13. Birthplace: Ky.

MOTHER — 14. Maiden name: Ellen Thomas

MOTHER — 15. Birthplace: Mo.

16. Informant: husband: Lt. Dean H. Harding (M.C.) USNR

Address: 7607 Eastern Avenue, N. W., Apt. 202, Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 2-20-46 (month) (day) (year)

Cemetery or crematory: Arlington National
Arlington, Va.

Location:

18. Funeral director: Warner E. Pumphrey W.E.P.

Address: 8434 GeorgiaAve, Silver Spring, Md.

19. 2-18 (Date rec'd by registrar) 19 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 Feb. 19 46, at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Jan 19 46 to 18 Feb. 19 46 and that I last saw h... alive on 18 Feb. 19 46

Immediate cause of death	DURATION
Valvular Heart Disease,	3 yrs
mitral stenosis	
Due to: Acute rheumatic fever	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: T. S. Barnes, Lt. Comdr. (M.C.) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 2-18-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(2/22/46)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-4

CERTIFICATE OF DEATH

★ 01722

Reg. Diat. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park - Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, Institution, or street address where death occurred:
Residence

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery.

City or town: Takoma Park.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Poplar Ave. Takoma Park
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: FREDERICK L. HARRIES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Mrs. Adah Harries.

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 21, 1870

8. AGE: Years	Months	Days	If less than one day
75	8	11	____ hrs. ____ min.

9. Birthplace: Haverford, Wales
(Town, county, and state)

10. Usual occupation: Retired Teacher.

11. Industry or business: D. G. Schools.

FATHER
12. Name: Rev. John Harries.
13. Birthplace: WALES.

MOTHER
14. Maiden name: JAYIES.
15. Birthplace: KENBY WALES

16. Informant: MRS. ADAH HARRIES
Address: 15 POPLAR AVE TAKOMA PARK.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: Feb. 5 1946 (month) (day) (year)

Cemetery or crematory: GLENWOOD CEMETERY

Location: WASHINGTON - D.C.

18. Funeral director: Arthur Harries.

Address: 1254 Irving St. N.W.

19. Feb 2 1946 (Date rec'd by registrar) J. Wilson Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2 1946, at 9 A.M.

21. I CERTIFY that death occurred on ths date above stated; that I attended deceased from 1943 to Feb. 2 1946 and that I last saw h. alive on Feb. 1, 1946

Immediate cause of death	DURATION
Cerebral thrombosis	7 days
Due to: Arteriosclerosis	20 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Charles T. Carroll M.D.
Charles T. Carroll, M.D. M. D. or other

Address: 6801 - 6th St., N.W., Wash., D.C. Date signed: 2/2/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01723

Reg. Dist. No. 216.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M 3/2/46

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 Days

Hospital, institution, or street address where death occurred:
U.S. NAVAL HOSPITAL, BETHESDA, MD.

How long in hospital or institution? 32 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: New York County:

City or town: Brooklyn,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 578 57th St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

George Joseph HART, S1c USNR

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W US	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 28, 1926

8. AGE: Years	Months	Days	If less than one day
19	2	26	hrs. min.

9. Birthplace: New York (Town, county, and state)

10. Usual occupation: U.S. Navy

11. Industry or business

FATHER 12. Name: George Hart

FATHER 13. Birthplace: New York

MOTHER 14. Maiden name: Beckman

MOTHER 15. Birthplace: New York

16. Informant: Mr. George Hart.

Address: 578 57th St., Brooklyn, N.Y.

17. removal (Burial, cremation, or removal. Which?) Date thereof 2-24-46 (month) (day) (year)

Cemetery or crematory

Location: Brooklyn, N.Y.

18. Funeral director: George W. Wise Co. J.C.F.

Address: 2900 M St. NW Washington, D.C.

19. 2-24 (Date rec'd by registrar) 19 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 Feb. 19 46 at 6:25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Jan 19 46, to 23 Feb. 19 46 and that I last saw him alive on 23 Feb. 19 46

Immediate cause of death	DURATION
Bronchopneumonia Lft	10 Da
Due to: Aspiration of infected contents of Rt Lung	
Due to: Lung abscesses Rt Lwr Lyb	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Pneumonectomy Rt

Date of op.

Autopsy results: none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: F. S. ASHBURN, Lt.Cdr. (MC) USN
M. D., or other

Address: US NH Bethesda, Md. Date signed 2-24-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

01721

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montg Co,

City or town: Gaithersburg Md,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2yr 8 Mo,

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montg

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mamie Eleanor Hart

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Archie C Hart

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 6th 1869

8. AGE: Years	Months	Days	If less than one day
1869 76	4	27	..... hrs. ..... min.

9. Birthplace: Culpepper Va.
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: " "

FATHER
12. Name: Thomas R Covington
13. Birthplace: Va,

MOTHER
14. Maiden name: Mary J Ashbey
15. Birthplace: Va,

16. Informant: Methodist Home, F M Wilson
Address: Gaithersburg .Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/5/46 (month) (day) (year)

Cemetery or crematory: Warrenton Cemetery

Location: Warrenton Va,

18. Funeral director: Ernest C Gartner

Address: Gaithersburg Md,

19. Feb 4 19 (Date rec'd by registrar) 14 Alma G Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 3rd 19 46 at 7.45 Am M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 23 - 19 46, to Feb - 3 - 19 46 and that I last saw h.er alive on Feb - 2 - 19 46

Immediate cause of death	DURATION
Senility & debility	2-3 years
Due to Arteria-sclerosis. Cer. T.B.	
Duration: Unknown.	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: William C. Miller M.D
M. D. or other

Address: Gaithersburg Md Date signed 2/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01724

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Monta. 9508-Biltmore Dr.
City or town Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9508- Biltmore Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cynthia Hartsook

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John A. Hartsook
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) November 30, 1861

8. AGE: Years	Months	Days	If less than one day
84			hrs. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name John A. Johnson
13. Birthplace Va.

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant John W. Wilkinson
Address 605 Market St., Wilmington, Del.

17. Removal-ship (Burial, cremation, or removal. Which?) Date thereof 2/25/46 (month) (day) (year)
Cemetery or crematory Evergreen Cemetery
Location Roanoke, Va.

18. Funeral director The S. H. Hines Co
Address 2901-14 - at N. W. Washington D. C.

19. Feb 2-5 (Date rec'd by registrar) 19 46 Josephine M Kheaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 19 46, at 6:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 36, to Feb. 24 19 46 and that I last saw h. alive on Feb. 24 19 46

Immediate cause of death	DURATION
Cardiac dilatation	1 day
Due to	
Due to	
Other conditions Cardiac arrythmia	
all ages	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged ststistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm A Johnson M.D. M. D. or other
Address 113 Carroll St. N.W. Date signed Feb 24 '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-d)

CERTIFICATE OF DEATH

01725

Reg. Dist. No. 2/3

FILM No. 100 FEB 15 1946

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Rockville, Md 32 yrs.
Hospital, Institution, or street address where death occurred:
203 W. Montg. Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty.
City or town: Rockville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 203 W. Monty. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mr. John Harwood

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 14, 1869 1868

8. AGE: Years	Months	Days	If less than one day
77			..... hrs. ..... min.

9. Birthplace: Buffalo N. Y. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
12. FATHER — Name: David Harwood
13. FATHER — Birthplace: Buffalo, N. Y.
14. MOTHER — Maiden name: Barbara Hofwood
15. MOTHER — Birthplace: Buffalo N. Y.
16. Informant: Nelda McKay
Address: 203 W. Monty. Ave.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 2/6/46 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cem.
Location: Maryland
18. Funeral director: Wm Reuben Turnbaugh
Address: Bethesda Maryland
19. 2/6/46 (Date rec'd by registrar) Josephine D. Hooton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 5 1946 at 6.25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/26 1946 to 2/5 1946 and that I last saw h.m alive on 2/5 1946

Immediate cause of death: Bronchial pneumonia — DURATION: 3 days
Due to: Myocardia insufficiency
Due to: Senility
Other conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: V. E. Hawks M.D. (M. D. or other)
Address: Rockville Md — Date signed 2/6/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

CERTIFICATE OF DEATH

01726

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, institution, or street address where death occurred:
Naval Hospital Bethesda, Md.

How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ill. County:

City or town: Savanna
(If outside city or town limits, write RURAL and give nearest town)

Street No. 116 4th St., Savanna, Ill.
(If rural, give LOCATION)

2.(a) If veteran, name war: X

3.(a) FULL NAME
Donald Maynard HAYENGA S/Sgt. USMC

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Dorothy Hayenga

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 10, 1921

8. AGE: Years	Months	Days	If less than one day
24	11	14	..... hrs. ..... min.

9. Birthplace: Ill.
(Town, county, and state)

10. Usual occupation: U.S. Marine Corp.

11. Industry or business:

FATHER
12. Name: Evert Hayenga
13. Birthplace: Ill.

MOTHER
14. Maiden name: Helen Reints
15. Birthplace: Ill.

16. Informant: Mrs. Dorothy Hayenga
Address: 116 4th St. Savanna, Ill.

17. removal (Burial, cremation, or removal. Which?) Date thereof 2-24-46 (month) (day) (year)

Cemetery or crematory: Savanna

Location: Savanna, Ill

18. Funeral director: Geo. W. Wise Co. J.C.F.

Address: 2900 M St., Washington, D.C.

19. 2-24 (Date rec'd by registrar) 19 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 Feb. 19 46, at 9:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 Feb. 1946, to 24 Feb. 1946 and that I last saw him alive on 24 Feb. 1946

Immediate cause of death	DURATION
Respiratory failure	
Due to: Cerebral Edema	1 day
Due to: Aneurysm Circle of Willis	6 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Aneurysm of Circle of Willis Date of op. 2/23/46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. Bruden (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed 2-24-46

STATE OF MARYLAND—CERTIFICATE OF DEATH

01727P

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

1. PLACE OF DEATH

County Montgomery — Registration Dist. No. 13

Village or City Silver Spring — No. 124 Hilltop Rd. — St., — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Mary Henderson

If U. S. Veteran, specify WAR no

(a) Residence: No. 124 Hilltop Rd., Silver Spring Ward.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Single

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of --

6. DATE OF BIRTH (month, day, and year) March 17, 1863

7. AGE — Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
82	11	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. --

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Edinburgh, Scotland (State or country)

FATHER

13. NAME John Henderson

14. BIRTHPLACE (city or town) Scotland (State or country)

MOTHER

15. MAIDEN NAME Janet Angus

16. BIRTHPLACE (city or town) Scotland (State or country)

17. INFORMANT Mrs. Mary Bengel

(Address) 124 Hilltop Rd., Silver Spring

18. BURIAL, CREMATION, OR REMOVAL

Place Druid Ridge Cem Date 2/20/ 19 46

19. UNDERTAKER WM. J. TICKNER & SONS

(Address)

20. FILED Feb 19, 19 46 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH February 18 (Month) (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from November, 1942, to February 18, 1946

I last saw h-- alive on February 17, 1946; death is said to have occurred on the date stated above, at 4:10 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Acute Dilatation of Heart	1946 10 Mos.
Cerebral Hemorrhage	1945 4 Months
Generalized Arteriosclerosis	1937 8 Years

Other Contributory Causes of Importance:

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy? —

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury — , 19 —

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. B. Waldrop M. D.

(Address) 943 Bonifant St. Silver Spring Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57)

CERTIFICATE OF DEATH

01728

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits write RURAL and give nearest town)

How long in above place of death? 11 hours

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hosp.

How long in hospital or institution? 11 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3001 Madison St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME ~~Unnamed Baby Boy~~ Milton Holford

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	white	—

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): February 2, 1946

8. AGE: Years | Months | Days | If less than one day: 11 hrs. 1 min.

9. Birthplace: Takoma Park, Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Paul Ferguson Holford

13. Birthplace: Washington, D.C.

MOTHER — 14. Maiden name: Ethell Frances Binns

15. Birthplace: Atlantic City, N.J.

16. Informant: Washington Sanitarium Records

Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 4, 1946 (month) (day) (year)

Cemetery or crematory: Sligo Nash Memorial Cemetery

Location: Riggs Rd. Hyattsville, Md.

18. Funeral Director: W. Arthur Dallas

Address: 254 Carroll St. Takoma Park, D.C.

19. Feb 3 1946 (Date rec'd by registrar) J. William Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2 1946, at 5 10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-2-1946, to 2-2-1946 and that I last saw him alive on 2-2-1946

Immediate cause of death	DURATION
Prematurity - 7 mo. preg	
Due to: Twin pregnancy	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Emma Hughes M.D. M. D. or other

Address: Takoma Park, Md. Date signed: 2-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

01729

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days - 7 months
Hospital, institution, or street address where death occurred: Washington Sanitarium + Hospital
How long in hospital or institution? 2 days - 7 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Col. County:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3001 Madison St.; Hyattsville, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Holford, Paul Ferguson, Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 2, 1946

8. AGE: Years	Months	Days	If less than one day
		2	hrs. min.

9. Birthplace: Takoma Park, Maryland (Town, county, and state)
10. Usual occupation:
11. Industry or business

FATHER
12. Name: Paul Ferguson Holford
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Ethel Frances Binns
15. Birthplace: Atlantic City, N.J.

16. Informant: Paul F. Holford, Jr.
Address: 3001 Madison St., Hyattsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 5 1946 (month) (day) (year)
Cemetery or crematory: Cemetery Gen. Mark. Manor
Location: Riggs Road, Hyattsville, Md.

18. Funeral director: J. Nicholas Walters
Address: 254 Carroll Ave. Takoma Park

19. Feb 5 1946 (Date rec'd by registrar) J. Nelson Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-4 1946, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-2- 1946 to 2-4- 1946 and that I last saw h... alive on 2-2- 1946

Immediate cause of death	DURATION
Prematurity - 7 mo. gestation	
Due to: Twin pregnancy -	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Emma Hughes M.D. M. D. or other
Address: Takoma Park, Md. Date signed: 2-4-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01730

Reg. Dist. No. 213 -

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rural - Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Scotland -
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Charles Washington Jackson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	married -

6.(b) Name of husband or wife: Hester Jackson -
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): 1873 Aug 22

8. AGE: Years: 72 | Months: 4 | Days: 17 | If less than one day: ... hrs. ... min.

9. Birthplace: Maryland - Montgomery County (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm -

FATHER
12. Name: Jack Jackson
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Maria Brent
15. Birthplace: Maryland -

16. Informant: Hester Jackson, wife
Address: Rockville RD#2

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Feb 5 1946 (month) (day) (year)
Cemetery or crematory: Lincoln Park
Location: Rockville, Md
16. Funeral director: Robert L. Snowden
Address: Rockville, Md.

19. 2/5/46 (Date rec'd by registrar) Josephine D. Wootton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2 19 46, at 8:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/15/46 19.., to 2/2 19 46
and that I last saw him alive on February 1 19 46

	DURATION
Immediate cause of death: Congestive Heart Failure	1 month
Due to: Hypertensive Heart disease	3 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wellington Wright. M. D. or other
Address: Rockville, Md Date signed: 2/2/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

01731

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. R# 2 - Colesville

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Robert Lee Johnson Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): February 8, 1946

8. AGE: Years	Months	Days	If less than one day
			8 hrs. 30 min.

9. Birthplace: Olney, Montgomery County, Md.

(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER — 12. Name: Robert Lee Johnson

13. Birthplace: Colesville, Maryland.

MOTHER — 14. Maiden name: Barbette Maria Poole

15. Birthplace: Edmor, Maryland

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 9 1946 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Buttonsville, Md.

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md.

19. Feb. 9 1946 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8 1946, at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8 1946 to February 8 1946 and that I last saw him alive on February 8 1946

Immediate cause of death	DURATION
Intracerebral Hemorrhage	8½ hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Sandy Spring, Md. Date signed

01732

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

Reg. Dist. No. 21-8

1. PLACE OF DEATH:

County Montgomery

City or town Germantown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Germantown, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William L. Jones

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Annie Miles

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1864

8. AGE:

Years	Months	Days	If less than one day
81	6	3	..... hrs. ..... min.

9. Birthplace Gaithersburg, Maryland (Town, county, and state)

10. Usual occupation Retired Farmer.

11. Industry or business

FATHER

12. Name Charles B. Jones

13. Birthplace Montg. Co. Md.

MOTHER

14. Maiden name Mary Elizabeth Jones

15. Birthplace Montg. Co. Md.

16. Informant Mrs. Grace Dorsey

Address Germantown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/21/46 (month) (day) (year)

Cemetery or crematory Great Oak Cemetery

Location Gaithersburg, Md.

18. Funeral director Wm. Reuben Dunphrey

Address Rockville, Md.

19. Feb 20 1946 Amelia G. Cooke

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 19 - 1946 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 28 - 1944 to Feb - 19 - 1946 and that I last saw h... alive on Feb - 18 - 1946

Immediate cause of death	DURATION
Heart failure	12 hours.
Due to Myocardial degeneration	2 years
Due to Mitral insufficiency	years
osteo - arthritis	years
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE William C. Miller, M.D. M. D. or other

Address Gaithersburg, Md. Date signed 2/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

01733

CERTIFICATE OF DEATH

Reg. Dist. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Parsonsburg Rural

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Sixty Years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rural Parsonsburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME R. Delaney King

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	W	Married

6 (b) Name of husband or wife Mary S. King

6(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) June 30 - 1874

8. AGE: Years	Months	Days	If less than one day
71	7	15	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Nursery

FATHER 12. Name John D. King

13. Birthplace Maryland

MOTHER 14. Maiden name Rebecca Watkins

15. Birthplace Maryland

16. Informant Mary S. King

Address Monrovia Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 17. 1946 (month) (day) (year)

Cemetery or crematory Damascus Md

Location Montgomery Co Md

18. Funeral director Roy W. Barber

Address Poolesville Md

19. Feb. 16 1946 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1946, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 10, 1943, to February 15, 1946, and that I last saw h[im] alive on February 4, 1946.

	DURATION
Immediate cause of death Coronary Occlusion	3 minutes
Due to Arteriosclerotic cardio-vascular disease.	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James P. Kerr M.D. M. D. or other

Address Damascus, Md. Date signed 2/16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01734

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day 22 hrs

Hospital, institution, or street address where death occurred:
Suburban Hospital-Bethesda, Md.

How long in hospital or institution? 1 day - 22 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 55 mm St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Mrs Dena M. Kingsley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1882

8. AGE: Years	Months	Days	If loss than one day
63	5	6	..... hrs. ..... min.

9. Birthplace ? Pennsylvania
(Town, county, and state)

10. Usual occupation Economic Analyst

11. Industry or business Dept. of Congress

FATHER 12. Name Geo. Kingsley

13. Birthplace ?

MOTHER 14. Maiden name Julia Reddington

15. Birthplace ?

16. Informant

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2-14-46 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director S. P. Gleason Co.

Address 2901 - 14th St. N.W.

19. 2-14-46 19 (Date rec'd by registrar) W E Jobes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14 1946, at 7 55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11 Feb 1946, to 14 Feb 1946

and that I last saw h alive on 14 Feb 1946

Immediate cause of death	DURATION
Coronary Occlusion	3 days
Due to Hypertension & Cardio vascular disease	?
Due to Arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Richmond, MD M. D. or other

Address 5532 Western Ave Chevy Chase 15, Md. Date signed 2-14-46

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (No 2)

CERTIFICATE OF DEATH

01735

Reg. Dist. No. 21 7

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital

How long in hospital or institution? 2 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Clarksville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Miss Margaret Kubel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
43			..... hrs. ..... min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Ernest Kubel

FATHER 13. Birthplace Washington, D.C.

MOTHER 14. Maiden name Pauline Hereu

MOTHER 15. Birthplace

16. Informant Hospital record

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb. 7, 1946 (month) (day) (year)

Cemetery or crematory

Location 2901-14th St. N.W. Washington D.C.

18. Funeral director L.J. Hines Co.

Address 2901-14th St. N.W. Washington D.C.

19. Feb 7 (Date rec'd by registrar) 1946 Gertrude K. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1946 at 12:24 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam case 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Intra-cranial hemorrhage	3 hrs.
Due to Fracture of base of skull (accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-7-46

Where did injury occur? Aston (City or town) Monty (County) Md (State)

Injured at home, farm, Industry, public place (where?) Highway

Means of injury Auto accident Injured at work? no

23. SIGNATURE Frank J. Burkhart M.D. M. D. or other

Address Gaithersburg, Md. Date signed 2/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01736

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Emory Grove, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Emory Grove, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ernestine Mae Lancaster

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 21, 1946

8. AGE: Years | Months | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace Gaithersburg Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Bernard A. Lancaster

FATHER 13. Birthplace Gaithersburg Md

MOTHER 14. Maiden name Mary Lee Mooney

MOTHER 15. Birthplace Gaithersburg Md

16. Informant Mary Lee Lancaster

Address Gaithersburg, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 27 1946 (month) (day) (year)

Cemetery or crematory Brookside

Location Laytonsville, Md. (Rural)

18. Funeral director Ray D. Barber

Address Laytonsville Md.

19. Feb 26 1946 (Date rec'd by registrar) Charles H. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1946 at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 21 1946, to Feb 26 1946

and that I last saw h... alive on Feb 25 1946

Immediate cause of death	DURATION
Bronchopneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M.D.
M. D. or other

Address Gaithersburg Date signed Feb 26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01737

CERTIFICATE OF DEATH

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Emory Grove rural

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Emory Grove Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Estine Cassy Lancaster

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Sngl

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21 - 1946

8. AGE:

Years	Months	Days	If less than one day
0	0	3	hrs. min.

9. Birthplace at Home Montgomery Co Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Bernard A Lancaster

13. Birthplace Emory Grove Md

MOTHER

14. Maiden name Mary Lee Warren

15. Birthplace Md

16. Informant Eleanor Warren

Address Gaithersburg Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb 24-1946 (month) (day) (year)

Cemetery or crematory Brooke Grove Md

Location Montgomery Co Md

18. Funeral director Roy W Barlow

Address Laytonsville Md

19. Feb 24 1946 (Date rec'd by registrar) Rhoda G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1946, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 21 1946, to Feb 23 1946, and that I last saw h- it- alive on Feb 23 1946.

Immediate cause of death	DURATION
Bronchopneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Gaithersburg Md Date signed 2/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

01738

CERTIFICATE OF DEATH

Reg. Diat. No. 228

1. PLACE OF DEATH:
County: Montg Co,
City or town: Germantown, Rural, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montg
City or town: Germantown Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rnral, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Major Lee

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col,	Married

6.(b) Name of husband or wife: Carrie Lee
6.(c) If alive, give age: 52 years
7. Birth date of deceased (mo., day, yr.): June 12th

8. AGE: Years	Months	Days	If less than one day
1888 57	7	24	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laboner
11. Industry or business: "

FATHER
12. Name: Henry Lee
13. Birthplace: Md,

MOTHER
14. Maiden name: Amanda Warfield
15. Birthplace: Md

16. Informant: Carrie Lee
Address: Germantown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/9/46 (month) (day) (year)
Cemetery or crematory: Brownstown, Cemetery
Locaiion: Brownstown Md,
18. Funeral director: Ernest C Gartner
Address: Gaithersburg Md

19. Feb 8 1946 (Date rec'd by registrar) Amanda G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 6th 1946, at 12.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb-2- 1946, to Feb-6- 1946 and that I last saw him alive on Feb-4- 1946

Immediate cause of death	DURATION
Acute Heart failure	30 minutes
Due to Bronchitis	1 week
Due to Senility	—
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William E Miller M.D.
M. D. or other
Address: Gaithersburg Md Date signed 2/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-22)+

CERTIFICATE OF DEATH

01739

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? 98 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

Street No. 6406 Beechwood Drive (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Bessie Litzenberg

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Col H L Litzenberg Jr. 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20 1903

8. AGE: Years	Months	Days	If less than one day
42	11	22	hrs. min.

9. Birthplace Philadelphia Penn. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Dell S. Leech

13. Birthplace Philadelphia Pa.

MOTHER 14. Maiden name Elizabeth Johnson

15. Birthplace Elkton Md.

16. Informant Husband

Address 6406 Beechwood Dr. Ch. Ch. Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2/12/46 (month) (day) (year)

Cemetery or crematory Phila. Pa. Lebanon Cem.

Location Lansdowne Pa.

18. Funeral director Jos. Fawlers Sons

Address 1756 Pa. Ave. NW

19. 2/11 19 46 Wm E Jobes (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-11 19 46, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Rosedale 15 19 45, to 2-11 19 46

and that I last saw h.e alive on 19

Immediate cause of death	DURATION
Cancer of lungs, liver	
Due to and cancer of uterus, metastatic. Secondary.	
Due to Primary carcinoma of intestines. Surg. Duration, two years.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Cancer of uterus, lungs, liver

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sophie Nowakowsky M. D. or other

Address Suburban Hospital Date signed 2-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (58-c)

01740

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH
County: Montgomery
City or town: Clarksburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montg.
City or town: Clarksburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Rachel E. Mason

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: James H. Mason
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept-10-1871

8. AGE: Years: 74 | Months: 5 | Days: 3 | If less than one day: — hrs. — min.

9. Birthplace: Clarksburg, Md.
(Town, county and state)
10. Usual occupation: house-keeping
11. Industry or business: at home

FATHER
12. Name: John Henry Green
13. Birthplace: Clarksburg, Md.

MOTHER
14. Maiden name: Mary Eliza Hyma
15. Birthplace: Clarksburg, Md.

16. Informant: Matilda Mason Gray
Address: Clarksburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 18-1946 (month) (day) (year)
Cemetery or crematory: St. Johns
Location: Monte Carlo

18. Funeral director: Bruce W. Barbour
Address: Laytonsville md

19. Feb 14 1946 (Date rec'd by registrar) Alvada G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 13 - 1946, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January - 20 - 1946, to Feb - 13 - 1946
and that I last saw her alive on Feb - 13 - 1946

	DURATION
Immediate cause of death: Septicemia	1 week
Due to: abscess -	1 week
Due to: Bed sore	1 week
Other conditions: Inflammatory rheumatism	24 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William C. Miller, M.D. (M. D. or other)
Address: Gaithersburg, Md. Date signed: 2/13/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for addition of color & sex of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

CERTIFICATE OF DEATH

FILM No. I 01 MAY - 2 1946

01741

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Silver Spring, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 9508- Biltmore Av Drive

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Lily McConnell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female 74-	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 30, 1871

8. AGE: Years	Months	Days	If less than one day
74			hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER — 12. Name: Abel McConnell

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Louisa --

15. Birthplace: Unknown

16. Informant: Mrs. Blanche Harris

Address: Stoneleigh Courts, Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 1, 1946 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Washington, D.C.

18. Funeral director: The S.H. Hines Co

Address: 2901-14 - st N.W. Wash. D.C.

19. Feb 28 1946 (Date rec'd by registrar) Josephine McCauffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26, 1946, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 22 1946 to Feb. 26 1946 and that I last saw h E K alive on Feb. 26. 46 19

	DURATION
Immediate cause of death: Cardiac dilatation	Indefinite
Due to: Old age, general debility	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Wm. A. Shannon M.D. M. D. or other

Address: 3 Carroll St. N.W. Wash DC Date signed: Feb. 26, 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on FILM No. I 04 MAY 28 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

CERTIFICATE OF DEATH

01742

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution) or street address where death occurred: 24 East Woodbine St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 24 E. Est. Woodbine St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Horace Lyman McCoy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Evelyn E.,
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 5, 1888

8. AGE: Years	Months	Days	If less than one day
57 59			..... hrs. ..... min.

9. Birthplace: Portland Oregon (Town, county, and state)
10. Usual occupation: Director of Insurance
11. Industry or business:

FATHER
12. Name: George McCoy
13. Birthplace: Virginia

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Horace L. McCoy
Address: 24 East Woodbine St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 6, 1946 (month) (day) (year)
Cemetery or crematory: Arlington Natl. Cem.
Location: Arlington Virginia

18. Funeral director: Wm Reuben Humphrey
Address: Bethesda Md

19. 2/5 (Date rec'd by registrar) 19 46 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 4 1946, at 7:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Asphyxia by hanging	Unk.
Due to: Suicide	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 2-4-46
Where did injury occur? Chevy Chase (City or town) Mont. (County) Md. (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bronhard M.D. (Med. Exam.) M. D. or other
Address: Gaithersburg Md. Date signed: 2-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01743

CERTIFICATE OF DEATH

FILM No. I 00 MAR 4 - 1946

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 717 50th St., N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

MORROW, Lewis (n)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife: Mrs. Irene Morrow

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4 April 1892

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
53 ~~13~~	10	16		

9. Birthplace: N.C.
(Town, county, and state)

10. Usual occupation: veteran

11. Industry or business:

FATHER
12. Name: Salis Morrow
13. Birthplace: S.C.

MOTHER
14. Maiden name: Rachel Simmons
15. Birthplace: N.C.

16. Informant: wife: Mrs. Irene Morrow

Address: 717 50th St., N.E., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-23-46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Ernest W. Jarvis GLH

Address: 1432 U St. NW Washington, D.C.

19. 2-20 (Date rec'd by registrar) 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 Feb. 1946 at 2:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Feb. 1946 to 20 Feb. 1946 and that I last saw him alive on 20 Feb. 1946

Immediate cause of death	DURATION
coronary thrombosis	24h.
Due to: Hypertension 7y	
Due to: arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none or above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. W. Thompson
C. W. THOMPSON, Lt. Comdr. (MC) USNR
M. D. or other

Address: US N.H., Bethesda, Md. Date signed: 2-20-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

01744

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:

County: Montg Co,

City or town: Gaithersburg Md,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montg

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry Wooten Mullican

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Alice Ward Mullican

8.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): March 17th 1873

8. AGE: Years	Months	Days	If less than one day
1875 70	10	24	hrs. min.

9. Birthplace: Gaithersburg Md,
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER — 12. Name: Henry Mullican

13. Birthplace: Md

MOTHER — 14. Maiden name: Susan Aroun

15. Birthplace: Md

16. Informant: Alice Mullican

Address: Gaithersburg Md,

17. (Burial, cremation, or removal. Which?) Burial — Date thereof (month) (day) (year) 2/13/46

Cemetery or crematory: Forest Oak Cemetery

Location: Gaithersburg Md

18. Funeral director: Ernest C Gartner

Address: Gaithersburg Md

19. (Date rec'd by registrar) Feb 12 1946 — Registrar: Abner H Cook

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 11 1946, at 11:46 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. med Ex and 19 to 18

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	1/2 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Fred J. Brookes M. D. Dep. med Exam
M. D. or other

Address: Gaithersburg md Date signed 2-11-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

01745

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery County
City or town: Takoma Park Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 805 Maple Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 537 Peabody St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Alva C. Murphy

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Maude Murphy
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 16th 1874

8. AGE:

Years	Months	Days	If less than one day
71			hrs. min.

9. Birthplace: Alabama (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs Kendall D Phillips
Address: 537 Peabody St N.W.

17. Cremating (Burial, cremation, or removal. Which?) Date thereof: Feb. 20th 1946 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cem.
Location:

18. Funeral director: Chevy Chase Funeral Home
Address: By Ernest A. Adams 5103 Wis. ave nw.

19. 2/20 1946 (Date rec'd by registrar) J. D. Dudley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 20, 1946 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 7, 1946, to Feb. 20, 1946 and that I last saw h. alive on Feb. 19, 1946.

	DURATION
Immediate cause of death: Congestive heart failure	3 days
Due to: Arterio sclerosis	Indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. or other
Address: 6911 5th st. nw. Date signed: 2/20/46
Wash. D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

01746

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months 4 days

Hospital, Institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 7 months 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2029 Connecticut Ave., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Eleanor Lockie Newmeyer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ Edwin Jonathon Newmeyer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Deceased Dec. 30, 1877

8. AGE: Years 68 | Months 1 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Scotland (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business None

FATHER 12. Name Johnson

13. Birthplace Deceased

MOTHER 14. Maiden name Deceased

15. Birthplace

16. Informant Washington Sanitarium & Hospital Records

Address Takoma Park, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2-16-46 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director The D.H. Hines Co

Address 2901-14th St. N.W.

19. Feb 14 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1946 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 1946 to Feb 14 1946 and that I last saw h.. alive on Feb 14 1946

Immediate cause of death	DURATION
Pneumonia (Hypostatic)	Terminal
Due to Cerebral Hemorrhage	7 mos.
Due to Hypertension	Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert A. Hare M.D.

M. D. or other

Address Takoma Park, Md. Date signed 2/14/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 99-D

CERTIFICATE OF DEATH

01747

Reg. Diat. No. 774

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital or Institution, street address where death occurred:

415 E. Melbourne St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 415 E. Melbourne St.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: EPPA R. NORRIS

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Lulu Laskey

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 16th. 1861

8. AGE: Years	Months	Days	If less than one day
84	10	5	..... hrs. ..... min.

9. Birthplace: Lancaster Co. Va.

(Town, county, and state)

10. Usual occupation: Retired Goverment Employee

11. Industry or business

FATHER 12. Name: Eppa Norris

13. Birthplace: Va.

MOTHER 14. Maiden name: Elizabeth A. Livingston

15. Birthplace: Va.

16. Informant: Mr. Eppa L. Norris

Address: 415 E. Melbourne St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 23 - 1946 (month) (day) (year)

Cemetery or crematory: Glenwood

Location: Washington, D. C.

18. Funeral director: Warner E. Pumphrey

Address: 8434 Ga. Ave. Silver Spring, Md.

19. Feb 22 1946 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 21 1946 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 1946 to Feby 21 1946

and that I last saw h.. alive on Feby 21 1946

Immediate cause of death	DURATION
Hypertensive heart disease	3 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John M. Andrew M.D.

M. D. or other

Address: 120 Colesville Rd Silver Spring, Md. Date signed: 2-21-46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-e) ⊥

CERTIFICATE OF DEATH

01748

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 Days

Hospital, Institution, or street address where death occurred:
Naval Hospital, Bethesda, Md.

How long in hospital or institution? 14 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ____ County: ____

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 471 "H" St. NW
(If rural, give LOCATION)

2.(a) If veteran, name war: ____

3.(a) FULL NAME
OATES, Carson Claggett Mach USCGR.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Edna Oates

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 29, 1904

8. AGE:	Years	Months	Days	If less than one day
	41	4	14	____ hrs. ____ min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: U. S. Coast Guard

11. Industry or business: ____

FATHER
12. Name: George Oates (dec)
13. Birthplace: Virginia

MOTHER
14. Maiden name: Dollie Melon
15. Birthplace: West Virginia

16. Informant: Mrs. Edna Oates
Address: 471 "H" St. NW Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-18-46 (month) (day) (year)

Cemetery or crematory: Arlington, National

Location: Arlington, Virginia

18. Funeral director: George W. Wise J.C.F.

Address: 2900 "M" St. NW Washington, D.C.

19. 15 Febuary 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 February 1946 at 0340 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2 1946 to February 15 1946 and that I last saw him alive on Feb. 14, 1946

Immediate cause of death	DURATION
Compression of vital cerebral centers	1 mo.
Due to: Metastatic Carcinoma of brain	About 4 mos.
Due to: Bronchogenic carcinoma of lung with multiple brain metastases. Cured.	
Other conditions: Metastases to mediastinal lymph nodes and adrenals.	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: Carcinomatosis, brain, lung, adrenals

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

H. L. JONES, Comdr. (MC) USNR
SIGNATURE M. D. or other

Address: USNH Bethesda, Md. Date signed 2-15-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

01749

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montg, Co,
City or town: Gaithersburg, Md,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 84yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montg
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Elizabeth Offutt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Richard Offutt

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 17th 1862

8. AGE: Years	Months	Days	If less than one day
84	0	24	..... hrs. ..... min.

9. Birthplace: Gaithersburg Md,
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER — 12. Name: John Selby
13. Birthplace: Md,

MOTHER — 14. Maiden name: Magarett Bowman
15. Birthplace: Md

16. Informant: Walter Offutt
Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/13/46 (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg. Md,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg Md,

19. Feb 12 1946 Alvada G Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 11 1946, at 12.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945 to Feb 1946
and that I last saw h.. alive on Feb 10 1946.

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
High Blood Pressure	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Gaithersburg Md Date signed 2/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

01750

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Monty.
City or town: Takoma Park.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 905 Orchard
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 905 Orchard
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: JOHN F. OYEMAN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife: EMMA Eliz. OYEMAN
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): SEPT. 14, 1882

8. AGE:	Years	Months	Days	If less than one day
	63	4	23	..... hrs. ..... min.

9. Birthplace: BALTO. CO. Md. (Town, county, and state)
10. Usual occupation: SALESMAN - REAL ESTATE
11. Industry or business

FATHER
12. Name: ROBT. C. OYEMAN
13. Birthplace: BALTIMORE, Md.

MOTHER
14. Maiden name: ANNA M. GUNTRAM
15. Birthplace: BALTO. CO., Md.

16. Informant: EVALENA C. OYEMAN
Address: 2904 EVERGREEN AVE, BALTIMORE Md.

17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof FEB 7, 1946 (month) (day) (year)
Cemetery or crematory
Location: BALTIMORE Md.
18. Funeral director: Wilbur Ottenberg
Address: 247 Carroll St., Takoma Park, D.C.
19. Feb 7 1946 (Date rec'd by registrar) J. Wilbur Reddy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/7/46; 19 46; at 12 45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 45, to 2/7 19 46
and that I last saw him alive on 2/6 19 46

	DURATION
Immediate cause of death: Carcinoma of Gall Bladder & Liver	4 mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Infected carcinomas gall bladder cancer of liver. Date of op. 1/9/46
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: O'H Duffy M.D. M. D. or other
Address: 4200 - 9st NW. Date signed: 2/7/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-10M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

01751

Reg. Dist. No. 223

1. PLACE OF DEATH: Monty. Co.
County 100 Baltimore Ave.,
City or town Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Va. County
City or town Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1917 N. Troy Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Loura O'Neil Park

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Frank E. Park
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar 24, 1871

8. AGE: Years	Months	Days	If less than one day
74			..... hrs. ..... min.

9. Birthplace: Miss. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Thomas O'Neil
13. Birthplace: Miss.

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: J. D. Park
Address: 1917 N.Troy St.,Arlington,Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof March 2,1946 (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetery
Location: Baltimore, Md.

18. Funeral director: S. H. Hines & co.
Address: 2901 14th St.N.W., Wash, D.C.

19. Feb 28 1946 (Date rec'd by registrar) J. Wilson Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 28 1946, at 11 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1946, to Feby 28 1946, and that I last saw h.. alive on Feby 27 1946.

	DURATION
Immediate cause of death: Lobar Pneumonia	4 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: John M. Andrew M.D.
Address: Silver Spring Md. M. D. or other
Date signed 2-28-46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

01752

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4826 North La
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Montg.
City or town Bethesda Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. 4826 North Lane (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Ella May Penrose

3. (b) Social Security Number

4. Sex Female
5. Color or race white
6.(a) Single, married, widowed, or divorced widowed
6.(b) Name of husband or wife Junius M.
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Nov. 11, 1871

8. AGE: Years 74 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Illinois (Town, county, and state)
10. Usual occupation Housewife.
11. Industry or business

FATHER
12. Name John J. Clavin
13. Birthplace Ireland

MOTHER
14. Maiden name Josephine Parker
15. Birthplace New York

16. Informant Wm Alva Penrose
Address 4826 North La. Bethesda

17. Shipment Date thereof 2/21/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Riverside Cemetery
Location Sterling, Illinois
18. Funeral director Wm Reuben Pumphrey
Address 7557 Wis. Ave. Bethesda Md

19. 2/21 1946 Wm E [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1946, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1945, to Feb 20 1946
and that I last saw her alive on Feb 18 19

Immediate cause of death Coronary Thrombosis — DURATION 2 days

Due to Arteriosclerotic Heart Disease — Several years

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] MD
M. D. or other
Address 5016 Georgetown Rd Date signed 2/20/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 017532 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, Institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Katie Daisey Poole

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Mr. Oscar Kirby Poole

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 27 - 1864

8. AGE:

Years	Months	Days	If less than one day
81	9	21	..... hrs. ..... min.

9. Birthplace Goshen, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER

12. Name John Daisey

13. Birthplace ?

MOTHER

14. Maiden name Mary Ellen Chaloner

15. Birthplace ?

16. Informant Mrs. Mabel Poole Walker

Address Gaithersburg, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof 2/20/46 (month) (day) (year)

Cemetery or crematory Monocacy Cemetery

Location Beallsville, Md.

18. Funeral director Parker Funeral Home

Address Gaithersburg, Md.

19. Feb 18 1946 (Date rec'd by registrar) J. Wm. Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1946 at 9 P. M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Feb 6 1946 to Feb 17 1946 and that I last saw her alive on Feb. 17, 1946

	DURATION
Immediate cause of death terminal Broncho-pneumonia	48 hrs
Due to Multiple lung abscesses	2 wks. ?
Due to Chronic Bronchiectasis	yrs. ?
Other conditions Coronary & gen. sclerosis	yrs ?
Atherosclerosis & mural thrombi & gastro	

(Include pregnancy within 3 months of death) Pyonephritis

Major findings of operations no operation Date of op.

Autopsy results As noted above plus rectal polyp; diverticulosis, ventral hernia.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas. U. Calver M.D. M. D. or other

Address Silver Spring, Md. Date signed 2-18-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01754

Reg. Dist. No. 212

1. PLACE OF DEATH:
County Montgomery
City or town Boyd
(If outside city of town limits, write RURAL and give nearest town)
How long in above place of death? 77
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montg
City or town Boyd
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ambrose Bernard Reid

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 1 - 1868

8. AGE: Years	Months	Days	If less than one day
77	11	0	..... hrs. ..... min.

9. Birthplace Boyd, Montg Co Md (Town, county and state)
10. Usual occupation Retired farmer
11. Industry or business

FATHER
12. Name Aloysius Reid
13. Birthplace Maryland

MOTHER
14. Maiden name Sarah Feaster
15. Birthplace Maryland

16. Informant Miss Eulah Reid
Address Boyd, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/4/46 (month) (day) (year)
Cemetery or crematory St Marys
Location Barnesville, Md
18. Funeral director William B. Hilton
Address Barnesville, Md
19. Feb. 3 1946 (Date rec'd by registrar) Mrs. C.C. Hilton By Mrs. C.C. Hilton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1st 1946, at 2 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1910 to Feb 2 1946 and that I last saw h.. alive on Jan 29 1946

Immediate cause of death	DURATION
Coronary occlusion	10 Minutes
Due to Genl arterial Sclerosis	20 yrs
Due to	
Other conditions Cerebral Hemorrage	1941

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE Upton D Mouser M.D M. D. or other
Address Damonville Md Date signed Feb 3 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

CERTIFICATE OF DEATH

01755

FILM No. 100 FEB 18 1946

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 days
Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hosp.
How long in hospital or institution? 34 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wash.
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Nova Corinne C. Reightler

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph M. Reightler
6.(c) If alive, give age: 71 years
7. Birth date of deceased (mo., day, yr.): March 18, 1875

8. AGE: Years	Months	Days	If less than one day
70 -6-9	10	23	hrs. min.

9. Birthplace: Unionbridge, Maryland (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business: Own home

FATHER
12. Name: Charles Leeds
13. Birthplace: Union Bridge, Md.

MOTHER
14. Maiden name: Belle Snyder
15. Birthplace: Union Bridge, Md.

16. Informant & Husband
Address: Takoma Park, Md.

Washington San & Hosp Records

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-13-46 (month) (day) (year)
Cemetery or crematory: Broadfording Cemetery
Location: Broadfording, Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown, Md.

19. Feb 11 1946 (Date rec'd by registrar) J. Edwin Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10. 1946 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 7. 1946 to Feb. 10 1946 and that I last saw h[illegible] alive on Feb. 10 1946

Immediate cause of death	DURATION
Coronary Occlusion	Terminal
Due to Arteriosclerosis	7 years
Due to	
Other conditions Acute Infective Jaundice	2 days

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: O
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert A. Barclay M. D. or other
Address: Takoma Park Md. Date signed 2/11/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
FEB 13 1946
BUREAU V. R.

Sh. 5055

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 017567

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital Inc.

How long in hospital or institution? 19 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. R#4 Glenmont.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Richard Harlan Reynolds

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 6, 1945

8. AGE: Years	Months	Days	If less than one day
	1	12	hrs. min.

9. Birthplace: Olney, Montgomery County, Maryland
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Robert E. Reynolds
13. Birthplace: Heatsville, Virginia

MOTHER
14. Maiden name: Margaret Blose
15. Birthplace: Summerset, Penna.

16. Informant: Hospital records.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-20-46 (month) (day) (year)
Cemetery or crematory: Heathsville
Location: Heathsville, Virginia

18. Funeral director: J. Arthur Walters
Address: 254 Carroll St. N.W. Wash. D.C.

19. 2-18-1946 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18 1946 at 6:12 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 17 1946, to February 18 1946 and that I last saw him alive on February 18 1946

Immediate cause of death	DURATION
Brain Abscess	?
Due to: Encephalitis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or coroner

Address: Sandy Spring, Md. Date signed 2/18/46

VS A15 9-45-1M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age if deceased is shown on FILM No. I 00 FEB 25 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01757

Reg. Dist. No. 7-6

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 month
Hospital, institution, or street address where death occurred: 8200 Rockville Pike
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
Street No. 8200 Rockville Pike (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CHARLES ABRAM RIDOUT

3.(b) Social Security Number: 577-20-1835

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Gladys A. Ridout
6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): July 4, 1879

8. AGE: Years	Months	Days	If less than one day
66 -6-7-	7	11	hrs. ... min.

9. Birthplace: Martinsburg, Md (Town, county and state)
10. Usual occupation: Butler
11. Industry or business

FATHER
12. Name: James Ridout
13. Birthplace: Martinsburg, Md

MOTHER
14. Maiden name: Harriet Coleman
15. Birthplace: Martinsburg, Md

16. Informant: Gladys Ridout (wife)
Address: 8200 Rockville Pike

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: Feb 18 1946 (month) (day) (year)
Cemetery or crematory: Martinsburg Cem.
Location: Martinsburg, Md.

18. Funeral director: Snowden & Davis
Address: Rockville, Md.

19. 2/18 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 15 1946 at 3a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1946 to Feb. 15 1946 and that I last saw h[illegible] alive on Feb. 14, 1946

Immediate cause of death	DURATION
Carcinoma of Stomach.	6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E G Bauersfeld M. D. or other
Address: Bethesda, Md. Date signed 2/17/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

01758

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

Reg. Diat. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: R.F.D. Monrovia

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: R.F.D. Monrovia, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural - Near Damascus, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Rosa F. Royer

3. (b) Social Security Number

4. Sex: Female (FEMALE) | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: William J. Royer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 3, 1884

8. AGE: Years: 64 | Months: 7 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Renso County, New York. (Town, county, and state)

10. Usual occupation: None.

11. Industry or business

FATHER 12. Name: Charles W. Hage.

FATHER 13. Birthplace: New York.

MOTHER 14. Maiden name: Ellen M. Price

MOTHER 15. Birthplace: Maryland.

16. Informant: Mrs. Jesse Rockenhauser

Address: R.F.D. Monrovia.

17. Burial (Burial, cremation, or removal. Which?) Date thereof February 11, 1946 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Laytonsville, Md.

18. Funeral director: Roy W. Barber

Address: Laytonsville, Md.

19. Feb 9 1946 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8, 1946, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 1944 to February 8, 1946 and that I last saw h.E.R. alive on February 7 1946.

	DURATION
Immediate cause of death: Arteriosclerotic cardio-vascular disease	10 years.
Due to: CVD Cerebral thrombosis, right.	2 years.
Due to: Chronic glomerular nephritis.	3 years.
Other conditions: Senility.	3 years.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Jesse D. Kerr M.D. M. D. or other

Address: Damascus, Md. Date signed: 2/9/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92nd

01759

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Garrett Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, institution, or street address where death occurred:
12 Pembroke St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Garrett Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 12 Pembroke St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Sally Parks Rucker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

8.(b) Name of husband or wife Benjamen L.
8.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Sept. 8, 1850

8. AGE: Years	Months	Days	If less than one day
95	4	27	..... hrs. ..... min.

8. Birthplace Mo.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Burrel Parks
FATHER 13. Birthplace Virginia
MOTHER 14. Maiden name Paulina Davies
MOTHER 15. Birthplace Virginia
16. Informant Richard H. Akers
Address 7008 Hampden La.
17. Burial (Burial, cremation, or removal, Which?) Date thereof Feb. 6, 1946 (month) (day) (year)
Cemetery or crematory Rockville Union Cem.
Location Rockville, Maryland
18. Funeral director Wm Reuben Funeral Chapel
Address Bethesda Maryland
19. 2/5 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1946, at 2 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1930 to Feb. 4 1946
and that I last saw h[illegible] alive on Feb. 4 1946

Immediate cause of death	DURATION
(a) Chronic Valvular Heart disease.	
Due to	
Due to	
Other conditions Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Marion Burchead M.D.
M. D. or other
Address Silver Spring Md. Date signed 2/4/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

CERTIFICATE OF DEATH

01760

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, institution, or street address where death occurred:
Suburban Hosp. Bethesda, maryland
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 20 Bridge Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Helen Virginia Siever

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
F	W	

6.(b) ~~Name of husband or wife~~ School child
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11-26-'35

8. AGE: Years	Months	Days	If less than one day
10	2	18	..... hrs. ..... min.

9. Birthplace Rockville, maryland (Town, county, and state)
10. Usual occupation School child
11. Industry or business

FATHER
12. Name Jess Siever
13. Birthplace ? W. Virginia

MOTHER
14. Maiden name Lena Wittig
15. Birthplace ? Virginia

18. Informant Jess. Siever
Address Rockville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 16th 1946 (month) (day) (year)
Cemetery or crematory Redland Lutheran Cem.
Location Redland, Maryland

18. Funeral director W. Reuben Tumbleson
Address Bethesda Maryland

19. 2/16 1946 (Date rec'd by registrar) Mrs E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13-'46 1946 at 11 55 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 22 1946 to 2/13 1946 and that I last saw h.. alive on 2/13 1946

	DURATION
Immediate cause of death pneumonia	
Due to rheumatic fever	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results rheumatic heart, rheumatic pneumonia
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE S. T. Kimble, Jr. M. D. or other
Address Bethesda Suburban Hosp Date signed 2/13/46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01762

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Hours
Hospital, institution, or street address where death occurred:
N.H. Bethesda, Maryland,
How long in hospital or institution? 5 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: P.G.
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4160 Madison St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: STEVENS, William Shield V.B.P.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Emma L. Stevens
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 16 1876

8. AGE: Years	Months	Days	If less than one day
69	9	29	hrs. min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: veteran
11. Industry or business
FATHER 12. Name: Albert S. Stevens
FATHER 13. Birthplace: Virginia
MOTHER 14. Maiden name: Maria Miller
MOTHER 15. Birthplace: Virginia
16. Informant: Mrs. Emma I. Stevens
Address: 4106 Madison St., Hyattsville, Md.
17. burial (Burial, cremation, or removal. Which?) Date thereof 2-18-46 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia
18. Funeral director: Francis Gasch and Co.
Address: 4739 Baltimore Ave, Hyattsville Md.
19. 15 Febuary 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 14 1946, at 0955 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 14 1946 to Feb 14 1946 and that I last saw him alive on 14 Feb. 1946

	DURATION
Immediate cause of death	
Due to: Hypertensive Heart Disease	
Due to: Veterans Bureau Record	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. H. C. SMITH, Comdr. (MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 2-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (2/20/46)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

01761

Reg. Diat. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Wheaton RFD No 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montgomery
City or town: Wheaton RFD 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: ANNIE AMELIA SUGRUE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Patrick A
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 19 - 1897

8. AGE: Years	Months	Days	If less than one day
48			..... hrs. ..... min.

9. Birthplace: Montgomery Co Md (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business:
FATHER 12. Name: Lewis S Davidson
13. Birthplace: Montg. Co Md
MOTHER 14. Maiden name: Amy F. Shoemaker
15. Birthplace: Wash D C
16. Informant: Lester Davidson
Address: Wheaton RFD No 1
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jul 23 1946 (month) (day) (year)
Cemetery or crematory: Oak Hill
Location: Wash D.C.
18. Funeral director: The S H Lines Co
Address: 2901 - 14th St NW
19. Jul 21 1946 (Date rec'd by registrar) Josephine M Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-20 1946, at 4:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-18 1946, to 7-20 1946 and that I last saw her alive on 7-20 1946

Immediate cause of death	DURATION
Bronchial Asthma with Status Asthmaticus	48 hrs
Due to: Anoxia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of
Where did injury occur? no (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) no
Means of injury no Injured at work? no

23. SIGNATURE: Wm E. Purycar M. D. or other
Address: 5005 16th Ave Date signed 7-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

CO 7023

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

L★ 01763

Reg. Diat. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: MONT. COUNTY
City or town: SILVER SPRINGS
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? LIFE
Hospital, institution, or street address where death occurred:
1322 DALE DRIVE, SILVER SPRINGS
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD. County: MONT.
City or town: SILVER SPRINGS
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1322 - DALE DRIVE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CARRIE E TAYLOR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife: NONE
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): SEPT 12, 1876

8. AGE:

Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: WASHINGTON DC.
(Town, county, and state)
10. Usual occupation: RETIRED
11. Industry or business:

FATHER
12. Name: JAMES L TAYLOR
13. Birthplace: PENN.

MOTHER
14. Maiden name: LOUISA ELLIS
15. Birthplace: PENN.

16. Informant: MRS. FANNY HURLEY
Address: 1316 18th N.W.

17. WEDNESDAY (Burial, cremation, or removal. Which?) Date thereof 2-27-46 (month) (day) (year)
Cemetery or crematory: ROCK CREEK CEM.
Location: WASHINGTON, D.C.

18. Funeral director: Jas. Sanders Sons
Address: 1766 Lanier Ave NW

19. Feb 23 1946 (Date rec'd by registrar) Josephine McHaffie Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 Feb. 1946, at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 1946, to 23 Feb. 1946
and that I last saw h... alive on 20 Feb 1946

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Ascitis, Pleural effusion and General Anasarca	4 weeks
Due to:	
Other conditions: Diabetes Mellitus	8 years

(Include pregnancy within 3 months of death)

Major findings of operations: Multiple Fibroids of Uterus
Date of op. Jan. 1946
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maurice A. Belanger M.D.
M. D. or other
Address: 1150 Conn. Ave. Date signed: 2/23/46

Dr. Ellicott has been advised.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01764

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)

Street No. 8618 Garfield Street (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MRS. ANNA MARIE TELFORD

3.(b) Social Security Number

4. Sex: Fem.

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: George C. Telford

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Aug. 29, 1861

8. AGE: Years 84 Months 5 Days 8 If less than one day ... hrs. ... min.

9. Birthplace: Canada (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: David Little

13. Birthplace: Canada

MOTHER 14. Maiden name: Marie Tunks

15. Birthplace: Canada

16. Informant: Mrs. Helen Gillions

Address: 8618 Garfield St. Bethesda, Md.

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 2/9/46 (month) (day) (year)

Cemetery or crematory: Emmettsburg, Iowa

Location: Emmettsburg, Iowa

18. Funeral director: E. J. Foy

Address: Emmettsburg, Palo Alto Co Iowa

19. 2/9 (Date rec'd by registrar) 1946 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 7 1946, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1945, to Feb 7 1946

and that I last saw her alive on Feb 7 1946

Immediate cause of death: Respiratory failure

Due to: Carcinoma of the bladder with metastasis

Due to:

Other conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: [illegible] M.D. or other

Address: 8016 [illegible] Date signed 2/9/46

Evidence for addition of sex
& color is shown on

FILM No. 100 FEB 13 1946

01765

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years.
Hospital, institution, or street address where death occurred: Washington Sanitarium & Hospital
How long in hospital or institution? 5 Mo. 23 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland. County: Montgomery
City or town: Takoma Park. (If outside city or town limits, write RURAL and give nearest town)
Street No. 805 Greenwood Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lillian Christiena Thompson
3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife: Clarence Thompson
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept 25 1894

8. AGE: Years	Months	Days	If less than one day
51	4	11	... hrs. ... min.

9. Birthplace: Wilmington Delaware (Town, county, and state)
10. Usual occupation: Nurse
11. Industry or business
FATHER 12. Name: Joseph Dillman
13. Birthplace
MOTHER 14. Maiden name: Talitha Lodge
15. Birthplace
16. Informant: Sanitarium Records.
Address
17. Burial (Burial, cremation, or removal. Which) Date thereof: Feb 8, 1946 (month) (day) (year)
Cemetery or crematory: George Wash. Memorial Cemetery
Location: Riggs Road, Hyattsville, Md.
18. Funeral director: J. Arthur Salters.
Address: 27 Carroll St, Takoma Park, D.C.
19. Feb. 6 1946 (Date rec'd by registrar) J. William Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 5. 1946, at 11:43 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 194 to Feb 5 1946
and that I last saw her alive on Feb. 5. 1946.

	DURATION
Immediate cause of death: Inanition	Terminal
Due to: Carcinoma of Cervix	3 years
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: Robert A. Hare M.D. M. D. or other
Address: Takoma Park, Md. Date signed: 2/5/46

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

01766

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 36 Hours
Hospital, Institution, or street address where death occurred:
Suburban
How long in hospital or institution? 36 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Holly wood Park Silver Spring MD
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R F D # 2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sophia Regina Tichenor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Alfonso J. Tichenor
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): March 13 1863

8. AGE: Years	Months	Days	If less than one day
82	11	3 ~~24~~	hrs. min.

9. Birthplace: ~~Germany~~ Cleveland. Ohio
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: Unknown Frauendiener
13. Birthplace

MOTHER
14. Maiden name: Unknown.
15. Birthplace: do

16. Informant: Alphonsus J. Tichenor
Address: Rt 2. Silver Spring. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May. 20 - 1946 (month) (day) (year)
Cemetery ~~or crematory~~: Gates of Heaven.
Location: East Hanover. New Jersey.

18. Funeral director: Wayne E Pumphrey.
Address: 8430 Ga Ave. Silver Spring. Md.

19. 3/20 1946 (Date rec'd by registrar) Mrs E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 February 1946 at 2:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 January 1946 to 16 Feb. 1946 and that I last saw h.er alive on 15 Feb. 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: Hypertension & Cardio vascular renal disease.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Manning H. Alden M. D. or other
Address: 8004 Newell Court. S.S. Md. Date signed: 16 Feb 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

01767

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 39 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1515 Seminary Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jessie S Trumpour

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Frederick Trumpour

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1869

8. AGE: Years	Months	Days	If less than one day
77	0	18	..... hrs. ..... min.

9. Birthplace Harmonsburg, Pemsylvania (Town, county, and state)

10. Usual occupation RETIRED PHYSICIAN

11. Industry or business

FATHER 12. Name Hiram Smith

13. Birthplace PENNA.

MOTHER 14. Maiden name UNKNOWN.

15. Birthplace UNKNOWN.

16. Informant FRED J. TRUMPOUR

Address 1515 SEMINARY RD. SILVER SPRING MD

17. CREMATION. (Burial, cremation, or removal. Which?) Date thereof FEB 18 1946 (month) (day) (year)

Cemetery or crematory FORT LINCOLN

Location PRINCE GEORGES Co. MD.

18. Funeral director Warnes & Pumphrey.

Address 8434 - Ga Ave - Silver Spring. Md.

19. 2/21 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 FEBRUARY 1946, at 12:16 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 DECEMBER 1945 to 18 FEBRUARY 1946 and that I last saw h..r..y alive on 17 FEBRUARY 1946

Immediate cause of death	DURATION
(a) Myocardial infarction	
Due to (b) coronary sclerosis	
Due to (c)	
Other conditions Arteriosclerotic Kidneys	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results. Fibrosis of myocardium; Cancer of Lung

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Marshall Carvalho Jr. M.D.

M. D. or other

Address 8648 Georgia ave Silver Spring, Md. Date signed 18 Feb. 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21a)

CERTIFICATE OF DEATH

01768

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 1 mo. 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3901 Conn. Ave. N.W. Apt-502
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Agnes J. Vincent

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10, 1877.

8. AGE: Years 68 | Months 7 | Days 27 | If less than one day: hrs. min.

9. Birthplace: France (Town, county, and state)

10. Usual occupation: Retired Teacher

11. Industry or business

FATHER 12. Name: Henry Vincent
FATHER 13. Birthplace: France

MOTHER 14. Maiden name: Elizabeth Crimmins
MOTHER 15. Birthplace:

16. Informant: J. F. Kelleher
Address: 3901 Conn. Ave. N.W. Apt 502

17. Interment (Burial, cremation, or removal. Which?) Date thereof 2/8/46 (month) (day) (year)
Cemetery or crematory: Glenabora N. J.
Location: N J

18. Funeral director: Wm Reuben Humphreys
Address: Bethesda Md.

19. 2/8 19 46 Wm E Jobes Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 6 19 46 at 6:13 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from (7) Jan 1946 19 to 6/Feb/1946 19
and that I last saw h[illegible] alive on 6/Feb/1946 19

Immediate cause of death: aortic Valve Stenosis — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: Not granted.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Charles R. L. Halley M.D.
M. D. or other
Address: 801 Eye St. N.W. Date signed: 7 Jan 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (W7E)

CERTIFICATE OF DEATH

01769

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mons. 22 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 mons. 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)

State: Tenn. County:

City or town: Lawrenceburg,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 234 Hughs Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: WHITE, Taylor Ostine, S1c V-6 USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Della B. White

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6 January 1909

8. AGE: Years	Months	Days	If less than one day
37	1	0	hrs. min.

9. Birthplace: Tenn.
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: George Henry White
13. Birthplace: Tenn.

MOTHER
14. Maiden name: Anna Lou Rhodes
15. Birthplace: Tenn.

16. Informant: wife: Mrs. Della B. White
Address: 834 Concord Avenue, N.W., Wash., D.C.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 2-6-46 (month) (day) (year)

Cemetery or crematory:

Location: Lawrenceburg, Tenn.

18. Funeral director: Geo. W. Wise J.C.F.
Address: 2900 M St., N. W., Wash., D.C.

19. 2-6 (Date rec'd by registrar) 1946 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 Feb. 1946, at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 Nov. 1945, to 6 Feb. 1946 and that I last saw him alive on 6 Feb. 1946

Immediate cause of death	DURATION
Generalized peritonitis	4 days
Due to: Perforation of Duodenal ulcer post operative	4 days
Due to: gastrectomy (16 days)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ulcer perforating + bleeding duod. ulcer Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. Basherman M. D. or other

Address: USNH Bethesda, Md. Date signed: 2-6-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

01770

Reg. Diat. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
9 East Blackthorn St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Monty.
City or town Chevy Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. # 9 E. Blackthorn St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Violetta Strott Zies

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Emanuel S.
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1882

8. AGE: Years	Months	Days	If less than one day
63	3	17	hrs. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. FATHER Name John Charles Strott
13. Birthplace Baltimore, Md.
14. MOTHER Maiden name Mary Reus
15. Birthplace Baltimore Maryland
16. Informant Emanuel S. Zies
Address Same as above
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/19/46 (month) (day) (year)
Cemetery or crematory Louden Park Cemetery
Location Baltimore, Md.
18. Funeral director Wm Reuben Dumphrey
Address 7557 Wis. Ave. Bethesda, Md.
19. 2/19 1946 Wm E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 16 1946, at 10:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1943, to Feb 16 1946 and that I last saw her alive on February 16 1946

Immediate cause of death	DURATION
Acute Heart Dilatation	10 min
Due to Generalized Arteriosclerosis	
Nephrosclerosis	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE W Bell Wadsworth M.D.
M. D. or other
Address 963 Bonifant St Silver Spring Date signed 2/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15